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**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**MARISSA M. GONZALES;**<br>**aka MARISSA D. MONCADA**<br>**141 South Grand Avenue**<br>**Anaheim, CA 92804**<br><br>**Registered Nurse License No. 526197**<br><br>Respondent. | Case No. 2010-460<br><br>**A C C U S A T I O N** |

Complainant alleges:

## PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 6, 1996, the Board of Registered Nursing issued Registered Nurse License No. 526197 to Marissa M. Gonzales; aka Marissa D. Moncada (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2010, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

## STATUTORY PROVISIONS

6. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

## REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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## COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

## FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. At all times herein mentioned, Respondent was assigned to work as a registered nurse in the Western Medical Center Surgical Floor.

10. On or about January 5, 2004, patient S.H., a 67 year-old male, was admitted to Western Medical Center with a diagnosis of chronic thyroiditis and follicular carcinoma of the thyroid gland. S.H. reported with an enlarged thyroid gland which resulted in a "pressure sensation" prior to this admission. The pre-operative history and physical do not note any established cardiac disease.

11. S.H. was prepped for surgery (routine thyroid removal) at 7:15 a.m. on January 5, 2004. The patient was received in the recovery room at 12:51 p.m. and was transferred to the floor in stable condition at 2:30 p.m. Respondent received the patient on the floor at 2:30 p.m.

12. Respondent's "Nursing assessment" at or around 2:30 p.m. includes documentation regarding the patient's neck dressing to be "dry and intact with drains to continuous bulb suction." Vital signs were documented at 4:00 p.m., but there was no documentation related to the output from the drain in the neck wound. There is no subsequent nursing charting until 7:00 p.m. when S.H. stated he was having difficulty breathing, and he was holding his neck. Documented vital signs were unstable, the physician and a Respiratory Therapist were called, and a Code Blue was called. CPR was performed, and a tracheotomy was performed.

13. S.H. subsequently experienced a bradycardia and a second resuscitation effort was started. Following this, S.H. was transferred to ICU and placed on mechanical ventilation. He remained unresponsive throughout the ICU course. A neurology consult and subsequent tests revealed severe anoxic encephalopathy secondary to the respiratory arrest.

14. On January 14, 2004, S.H.'s family decided to discontinue the ventilator and pursue comfort measures. S.H. died on January 15, 2004 at 4:57 p.m.

15. S.H.'s wife stated that she repeatedly advised Respondent between 3:00 p.m. and 6:30 p.m. that her husband felt like he was drowning, and that she, his wife, could see discoloration below his earlobes. She stated that Respondent did not look closely at his neck or bandage; she only adjusted his IV drip. S.H.'s wife also noted that the drainage from his neck into the drainage bag completely stopped after it was emptied upon his transfer to the Surgical Floor. She stated she was able to see S.H.'s neck beginning to swell, and advised Respondent of same. There is no medical record documentation of these conversations.

16. On July 13, 2009, Respondent was interviewed by a Division of Investigation Senior Investigator, Larry Moore. In this interview, Respondent stated that she was not the "primary caregiver" for S.H., a Licensed Vocational Nurse (LVN) named "Terry" was. Respondent stated that she and the LVN performed the patient assessment upon S.H.'s arrival on the floor. Respondent stated that she checked the dressing on S.H.'s neck and everything "seemed fine." Respondent stated that she did not observe any swelling on S.H.'s neck at that time.

17. Respondent stated that she returned "a few hours later" to check S.H.'s IV and administer antibiotics. Respondent stated that S.H.'s wife was present, and concerned about someone suctioning her husband and providing him with water. Respondent advised S.H.'s wife that Terry, the LVN, was S.H.'s primary caregiver and that she, Respondent, would pass her concerns on to Terry. There is no medical record documentation of these conversations.

18. Respondent stated that she returned at approximately 6:00 p.m. to check on S.H. and S.H. told her he could not breathe. Respondent stated she raised S.H.'s bed to see if this would help his breathing; it did not. Respondent stated that she went to "Mark," the charge nurse, and he returned to S.H.'s room and tried to improve S.H.'S breathing with no success. Respondent stated that Mark called a Code Blue and summoned the ICU staff to the room. The ICU staff arrived and began CPR. Respondent stated that the ICU staff called the physician, who came to the room and removed a blood clot from S.H.'s neck.

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19. Respondent stated that she did not see any swelling in S.H.'s neck, because the bandage on his neck covered a large area. She did not remember if his neck was discolored around the surgical site.

20. Respondent is subject to disciplinary action pursuant to Code section 2761(a) (a) on the grounds of unprofessional conduct, in that on the date indicated above, Respondent was guilty of gross negligence in her care of patient S.H. within the meaning of Regulation 1442, as follows: Respondent was grossly negligent in failing to assess S.H.'s status post operatively, which created a series of clinical events which ultimately led to S.H.'s anoxic encephalopathy. Respondent stated that she was not the "primary nurse" for S.H.; she stated that an LVN was the primary caregiver. Per licensure, an LVN cannot perform a complete physical assessment. Independent of assignment, as a Registered Nurse on the floor, Respondent was grossly negligent in failing to respond once made aware that S.H. was having difficulty breathing. Respondent was grossly negligent in simply "reporting" this event to another staff member rather than taking appropriate action herself.

**SECOND CAUSE FOR DISCIPLINE**

(Incompetence)

21. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 through 20, above.

22. Respondent is subject to disciplinary action pursuant to Code section 2761(a) (1) on the grounds of unprofessional conduct, in that on the date indicated above, Respondent was guilty of incompetence, as set forth above.

**THIRD CAUSE FOR DISCIPLINE**

(Unprofessional Conduct)

23. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 through 22, above.

24. Respondent is subject to disciplinary action pursuant to Code section 2716(a) (1), in that Respondent committed acts constituting unprofessional conduct, as set forth above.

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## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 526197, issued to Respondent Marissa M. Gonzales; aka Marissa D. Moncada.

2. Ordering Respondent Marissa M. Gonzales; aka Marissa D. Moncada to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/23/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

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